



JIBC

School of
Health Sciences

Paramedic Academy



Practicum
Educator
Guide

Advanced Care Paramedic

Advanced Diploma Program

Justice Institute of British Columbia

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The Justice Institute of BC (JIBC)

The JIBC is a post-secondary institution that provides education in the areas of justice and public safety. The mission of the JIBC is to provide innovative education and training for those who make our communities safe. The JIBC was established in 1978 and is comprised of three schools with a total of eleven academic departments. The main campus is located in New Westminster with regional campuses located in Kelowna, Victoria, Parksville and Prince George. The JIBC is recognized for supporting its academic offerings and programs with simulation exercises. In addition to programs within British Columbia, the JIBC is recognized as a world leader for effective education in public safety.

The Academies at the JIBC include the School of Public Safety and Security, School of Community and Social Justice, and the School of Health Sciences.

School of Public Safety and Security:

- Pacific Traffic Education Center
- Sheriff Academy
- Corrections and Community Justice
- Police Academy
- Fire & Safety Division
- Emergency Management Division

School of Community and Social Justice:

- Center for Counseling and Community Safety
- Center for Leadership
- Center for Conflict Resolution
- Center for Aboriginal Programs and Services

The School of Health Sciences:

- Center for Professional Health Education
- Paramedic Academy



The School of Health Sciences programs emphasize collaborative and interdisciplinary practice in both community and clinical settings. An integrative approach to health care utilizes the expertise of paramedics and other health professionals to improve access to care. An applied learning model incorporates the use of patient simulators and emergency scenarios. A hallmark of our paramedic training programs is the field application of the concepts and knowledge gained through online learning, didactic sessions, simulations and clinical opportunities. It can be accurately described as Applied Science. A simple to complex model is utilized to present program content and to build skill proficiency to paramedic students. Hospital and ambulance practicum opportunities form the bridge linking classroom and simulated learning sessions to the supervised application of skills in the real world. Your role as the Clinical/Field Educator is absolutely vital to this process.

Advanced Care Paramedic Program

This Advanced Care Paramedic (ACP) Program trains students to think critically, solve problems, and function as leaders while providing the highest possible standards of patient care. The Program extends the ‘simple to complex’ theory of instruction to the field environment. The practical learning environment is structured in a ‘ladder’ style, adding more complexity as the student demonstrates the ability to move forward.

Based on feedback from stakeholders and an internal review of the ACP Program in 2006, the School commenced a revision to the 2003-2009 program to address program recruitment, retention and reputation issues, as well as financial sustainability of the program. It was also recognized at that time that there were other environmental factors influencing a review of the program, these included:

- Significant technological advances which had led to changes in the scope of practice within paramedicine, and therefore required paramedics to have a broad depth and breadth of knowledge;
- The emergence of new or changed roles for paramedics within the healthcare sector

The process of revisions to the ACP program has been underway for three years with input from key stakeholders. The School received approval from the Ministry of Advanced Education and Labour Market Development in July 2010 to begin offering the 2010 ACP program in its re-designed format. The first cohort of students commenced the program in October 2010, and will complete in June 2012.

The major changes which have been implemented with the re-design of the ACP to the 2010 program format are:

Program Entry Requirements:

- A higher level of pre-requisite academic requirements to enter the program
- Addition of a physical fitness assessment requirement
- A new selection process that includes a panel interview and cognitive tests

Program Structure

- Additional student contact hours in a hybrid delivery model
- 3 Terms of varying lengths delivered over 18 – 22 months
- The program structure has been revised to make the program eligible for student loans
- Sixteen (16) additional days of clinical and practicum shifts

The basic structure of the Program is as follows:

Term 1

Health and Wellness
Professional Practice
Foundation of Paramedic Practice
Clinical Practicum I
Classic ACP Cases I

Term 2

Health Care in Communities
Classic ACP Cases II
Clinical Practicum II

Term 3

Complex ACP Cases
Clinical Practicum III

Program courses focus on the following themes:

- Clinician Skills
critical thinker, problem solver, leader, effective communicator
- Inter-professional Collaboration
working collaboratively with other health professionals in the patient's best interest
- Leadership
taking a leadership role in the workplace, practice and the community
- Life-Long Learning
continuously seeking and embracing knowledge
- Community-Based Emergency Health
understanding differing health care environments
- Science & Delivery of EMS
research methodology

Purpose of the Guide

One of the needs identified in feedback from clinicians and preceptors is written guidelines to help guide their education efforts. This guide is intended as both a resource that we will be updating and revising as the program evolves, and a 'how to manual' for students, clinicians, and preceptors.

The delivery of the practical application of ACP training should:

- Start the application of skills and procedures under close clinical and field educator supervision and direction
- Add more complex psychomotor skills and assessments only as the student demonstrates acceptable mastery and progress

Each hospital/field opportunity should follow the same basic format:

- Evaluate the student's starting point:
 - What Term and block of on-car practicum training are they in?
 - What have previous preceptors reported as strengths and weaknesses?
 - What does the student perceive as their personal strengths and weaknesses?
 - What does the Practicum Guide prescribe?

- Review the guidelines in this document with the student:
 - Where should the student be?
 - What competencies should the student be mastering?
 - What competencies are new to the student?

Evaluate the student's performance on the first few clinical/field encounters of the Term:

- Are they meeting the expectations?
- Do you need to tailor a specific plan to help the student?
- Do they require further challenge?

Some students will struggle at various points in the course. If your student is having difficulty, and you are unsure exactly what the stumbling block is, it is often the best approach to go back to the previous Term's objectives/ competencies. For example:

- Have the student perform only the previous Term's competencies, and work forward competency by competency on each call or patient contact, until the stumbling point is identified
- Work with the student to overcome their deficiency - don't allow the student to move ahead until they have overcome the roadblock

If at any point you need further information or support, you can contact the ACP Lead Instructor or the Program Coordinator through the Program Assistant: ACP Programs (604-528-5694).

Your role as the clinician/preceptor during the practicum is to:

- Supervise, coach, and evaluate paramedic students during their practice education shifts
- Seek out and provide clinical opportunities for students to meet program objectives and National Occupational Competency Profile
- Provide feedback to students related to their skills, interactions with patients, families, and other health care providers
- Complete documentation of competencies

**Emergency contact number for students to contact a SOHS representative:
604-528-5751.**

This number is available 24/7 if a student needs to suddenly leave a practicum shift. Examples where a student may suddenly leave may include, but are not limited to:

- A family emergency where their attendance is emergently required
- The student is involved in a motor vehicle incident, exposed to an infectious disease or contaminated with biological hazard and requires hospitalization or isolation
- Student has a medical emergency that requires further evaluation by a health care provider.

Understanding Competency Management

Paramedic Association of Canada - National Occupational Competency Profile

The Paramedic Association of Canada (PAC) is responsible for setting national competencies of paramedic practice. PAC does not determine the provincial scope of practice (i.e. what a paramedic is licensed to do in each province). In BC, scope of practice is defined by legislation, in the Emergency Medical Assistant Regulations, Appendix 3.

The PAC – NOCP skills are defined by the following practitioner levels:

- Emergency Medical Responder (EMR)
- Primary Care Paramedic (PCP)
- Advanced Care Paramedic (ACP)
- Critical Care Paramedic (CCP)

Competencies are specific to the practitioner’s level and are cumulative. Competencies are evaluated in the following settings and represented by a single letter:

- Awareness (X)
- Academic (A)
- Simulation (S)
- Clinical or hospital environment (C)
- On-car practicum (P)

Definition of Competency

The School of Health Sciences at the JIBC uses the PAC definition of competency to determine that a student has successfully completed all program competencies. Competence involves the demonstration of skills, knowledge and abilities in accordance with the following principles:

- Consistency– the ability to repeat practice techniques and outcomes
- Independence – the ability to practice without assistance from others
- Timeliness – the ability to practice in a time frame that enhances patient safety
- Accuracy – the ability to practice utilizing correct techniques and to achieve the intended outcomes
- Appropriateness – the ability to practice in accordance with clinical standards and protocols outlined within the practice jurisdiction

The Paramedic Association of Canada considers “consistency” to mean that students should perform each specific competency more than once in the required performance environment.

The ACP Program requires students to meet the PAC competency requirements. **The student must demonstrate competency a minimum of two times.** The competency tracking process reflects these competency requirements.

Tracking National Occupational Competency Profile Skills

Students record patient encounters, including treatment(s), assessments, and outcome(s) on Patient Care Records (PCRs) for the Ambulance Practicum or Clinical Worksheets (CWS) for the Clinical Practicum provided in their logbook. NOCP skills are determined after the patient encounter and are documented (by the student) on the CompTracker® web site.

Students are required to record each patient encounter during their practicum. Documentation must provide the data for the claimed competencies and must reflect the actions of the student. **If patient care is not documented, it is assumed that the care was not done.** Patient care documented by the student on the CWS/PCR supports the submitted NOCP skills. A separate CWS/PCR must be completed for each patient contact.

On the back of the CWS/PCR there is an NOCP Reference Guide that the student may complete. There is also an area where the clinician/preceptor can make comments regarding student performance. Comments may identify strengths and areas for improvement. This area is reviewed by clinicians/preceptors to determine the student's learning plan for the shift. Comments made by the clinician/preceptor must be initialed or signed at the bottom of the sheet.

See Appendix 6 for a sample CWS and PCR.

Clinical Worksheet (CWS)

The clinician evaluates and coaches the ACP student's integration of theoretical components in the hospital environment. The clinician is required to confirm the student's completion of a competency according to the PAC guidelines after every patient encounter by assigning an applicable code (described further in this manual) to the competency. The student is responsible to complete the CWS and claim NOCP competencies in the Clinical Practicum Logbook.

Patient Care Record (PCR)

The preceptor evaluates and coaches the ACP student's integration of theoretical components in the pre-hospital environment. The preceptor is required to confirm the student's completion of a competency according to the PAC guidelines after every patient encounter by assigning an applicable code (described further in this manual) to the competency. The student is responsible to complete the PCR and claim NOCP competencies in the Ambulance Practicum Logbook.

OR Practicum Competencies Form

The ACP student will complete an ACP OR Practicum Competencies Form (one per Anesthetist) during the OR clinical time. The signed off OR forms are to be attached to a clinical worksheet, as one needs to be completed for each of the OR patient contacts.

ACP OR Practicum Competencies			
	Total #s		
	S	U	T
Vital Signs			
Conduct non-invasive temperature (4.4.c)			
Measure BP/non-invasive monitor (4.4.f)			
Diagnostic tests			
Conduct oximetry/interpret (4.5.a)			
Conduct ETCO2/interpret (4.5.b)			
Upper airway/trachea			
Manual airway maneuvers (5.1.a)			
Suction oropharynx (5.1.b)			
Suction beyond oropharynx (5.1.c)			
Utilize oropharyngeal airway (5.1.d)			
ETT intubation (5.1.h)			
LMA			
Administer oxygen			
Nasal cannula (5.3.a)			
High concentration mask (5.3.d)			
Ventilation equipment			
Bag-valve-mask ventilation (5.4.a)			
Provide mechanical ventilation (5.4.d)			
Administer medications			
Subcutaneous (5.8.c)			
Intramuscular (5.8.d)			
Sublingual (5.8.h)			
Oral (5.8.j)			
Inhalation (5.8.l)			
Other (specify):			
Legend: S = Successful; U = Unsuccessful; T = Total attempts per skill/procedure *One card per Anesthetist			

ACP OR Practicum Competencies	
Student (Print Name)	
Date	
Anesthetist (Print Name)	
Signature	
Comments	
CWS References:	

Competency Management System

NOCP competencies are managed by a software program (CompTracker®) and through the Internet. CompTracker® provides students, instructors, clinicians, and administrative staff with the ability to communicate and track program progress on a daily basis. Students use the web to log attendance, classroom simulations, and acquisition of competencies. Instructors, ambulance preceptors, and hospital clinicians, sign off or validate student progress through the CompTracker® web site.

The software is developed and hosted by Great Big Solutions Ltd., in Edmonton, Alberta. This software is used by paramedic training agencies across Canada. Log in information with a password will be provided.

Any questions about the software program, hardware, or technical requirements can be addressed on the website www.studentlogbook.com or by calling Great Big Solutions at 1-866-432-3280. Help line support is available Monday, to Friday from 0800 to 1600 hours (MST) or via a chat line on the CompTracker® home page. *A quick reference for approving competencies on line is available on the CompTracker website, training tab or in the Appendices, Appendix 4.*

Validating NOCPs

After a student has claimed competencies, they must be validated by the clinician/preceptor. The clinician/preceptor and the student will review the claimed competencies. Any NOCP claimed by the student must be supported by documentation on the CWS or PCR.

Groups of students cannot claim the same integration competency for the same patient.

If competencies are not approved, a comment must be provided. A drop down menu provides consistent comments that can be used in addition to any comments that one wishes to add.

Students are encouraged to submit their competencies to the clinician/preceptor within 48 hours from the completion of their day or shift. Competencies submitted outside this time frame may not be counted toward competency completion and may not be validated by clinicians/preceptors.

NOCP Evaluation Parameter

In your role as a clinician/preceptor it is expected that you will:

- Supervise, coach, and evaluate paramedic students during their practice education shifts
- Seek out and provide opportunities for students to meet program objectives and National Occupational Competency Profiles
- Provide feedback to students related to their skills, interactions with patients, families, and other health care providers
- Complete documentation of competencies

Evaluation Code - SOHS Definition

A	Approved, completes objective competently (according to PAC definition of competency)
B	Requires prompting/assistance to complete objective
C	Fails to complete objective
D	Not observed/lack of volume
NB: Comments are required for any non-approved competency (graded as B, C or D)	

Job Dimensions

Paramedic Job Dimensions are best described as a sorting or categorization of the numerous job competencies that represent the performance areas that are critical to function as a paramedic. The Job Dimension evaluation reflects the student practice during a call or how the student processes a call. Each process is evaluated and graded according to the evaluation criteria as listed below. A Job Dimension evaluation is completed at the end of a block of shifts with the student or below when a clinician/preceptor may need to make comments/suggestions for improvement. The evaluation of job dimensions is completed on the CompTracker® website.

Logbook Submissions

After the last hospital and ambulance practicum shifts, the student logbook must be submitted to the ACP Program Assistant within 7 calendar days. The SOHS will respond and advise of the practicum status within 14 calendar days from the date received.

Work Related Injury

WorkSafe BC recognizes the JIBC, School of Health Sciences as an employer in relation to a work related injury. Paramedic students are covered by WorkSafe BC for injuries that happen during the hospital and/or ambulance practicum. If the work related injury occurs during the ambulance practicum, additional forms may be required to be completed by the BC Ambulance Service.

Should the student be involved in an incident that requires a debriefing please contact the SOHS Program Coordinator or Manager, Practice Education. JIBC Student Services and critical incident stress debriefers are available for students. *See Appendix 5 for the Work Related Injury Process and Forms.*

Patient Privacy

Students are responsible for adherence to the BCAS Patient Privacy Policy throughout their Practicum. *Please see Appendix 8 for a copy of this policy.*

Hospital/Clinical Practicum

Term 1

The objectives of the clinical opportunities in Term 1 are for the student to learn the application of their new skills and techniques in the clinical setting. The student should be applying and operating the monitor, while interpreting the ECG on every patient they can. Whenever possible they should be performing all of the simple psychomotor skills including IV insertion, taking vital signs, drawing up and administering medications*, and physical assessments.

The hospital sessions in Term 1 include:

- 4 days in the OR with an Anesthetist (1:1)
- 4 days in the ER with a Clinician (4:1)

At the beginning of the clinical time, you will need to closely supervise their efforts. Later they should be performing the core skills as you supervise through bedside supervision and receiving report.

Specifically the student should be able to:

- Complete an organized and thorough systems-based physical assessment skills
- Perform ACP core skills
- Perform all physical skills except intraosseous initiation
- Demonstrate effective interpersonal skills; including appropriate communications and good ability to receive feedback

Students may not know ‘when’ or ‘why’ to perform a particular skill, but they should be able to ‘perform’ when directed. A variety of exposures to different clinical situations helps the ACP develop their knowledge and understanding for patients they may encounter. Do not hesitate to provide students with a variety of patients.

**See Appendix 7 for a list of NOCP Medications by ACP Program Term*

Training Plan - Term 1

Review the plan with the student. Clarify expectations for both the student and clinician.

ACP Core skills include:

- Applying and operating the cardiac monitor, including trouble shooting, defibrillation and synchronized cardioversion
- Interpreting 3-lead rhythm strips
- Assessing vital signs
- Starting IV's
- Preparing and administering all types of medications*, as per their scope of practice
- Managing the airway, ventilation and oxygenation needs particular to the patient
- Performing physical assessment (including primary survey and head to toe), and reporting their findings to you
- Recording findings and treatments on the clinical worksheet
- Accurately self evaluating their performance
- Seeking out, and receiving feedback in a professional manner

Clinical Exposures are those tasks that the student must achieve to meet National Occupational Competencies that meet accreditation guidelines.

Skills and Procedures for this Term include:

- Endotracheal Intubation (ETI)
- Endotracheal Tube (ETT) Care
- ETT Suctioning
- Gastric Tube Insertion
- Peripheral IV Insertion
- Medication Administration*
- Chest Tube Care
- Core Temperature Monitoring
- Tracheotomy Care
- Intracranial Pressure (ICP) Monitoring
- Central Venous Lines/Central Venous Pressure (CVP) Monitoring
- Pulmonary Artery (PA) Monitoring

**See Appendix 7 for a list of NOCP Medications by ACP Program Term*

- Infusion Pump
- Foley & Non-Catheterization Urinary Drainage Systems
- Ostomy Care
- Arterial Blood Gases (ABG)/Arterial Line Monitoring
- Defibrillation
- Synchronized Cardioversion
- Transcutaneous Pacing (TCP)
- Valsalva Maneuver
- Nasopharyngeal Airway
- Mechanical Ventilation

Term 2

The Practicum in Term 2 is split into two parts: Part I takes place at the start of the Term and Part II takes place at the end of the Term.

Part I

Classroom topics include assessment, diagnosis and management of ‘Classic’ Chest Pain, Shortness of Breath, Trauma and Collapse calls. This is a dynamic period with rapidly escalating expectations and responsibilities for the student. This is likely the time that students will have the greatest difficulty implementing the many new assessment techniques and treatment modalities required.

The hospital sessions in Part I include:

- 4 shifts ER using the CCU and ICU environments as needed to complete competencies, with Clinician (4:1)

Part II

Classroom topics include assessment, diagnosis and management of ‘Classic’ presentations of toxicological, mental health and medical cases involving the endocrine and immune systems, anaphylaxis, GI/GU, and environmental cases involving heat and cold and drowning and submersion. In addition, students have now completed classroom topics in Obstetrics/Maternity and PEPP. It is expected in that in Part II of the Practicum students will demonstrate a higher level of clinical decision making skills in patient management than in Part I.

The hospital sessions in Part II include:

- 1 day with an ERP (4:1)
- 1 day Pediatrics (4:1)
- 1 day Obstetrics/Maternity(4:1)
- 1 day Geriatrics (4:1)

Please remember this is a generic template; some students progress quicker or slower. Customize this to best manage the student’s performance. If a student is ‘lagging’, please point this out to them and to the program staff.

Training Plan - Term 2

Review the plan with the student. Clarify expectations for both the student and clinician.

New this Term:

- Determine a patient's Chief Complaint
- Investigate cases using LOTARP/PPPQRST
- Emphasis is for the student to stay focused on the history taking model and to LISTEN to the responses
- Based on CC build a DDx and working PDx
- Functional exam
- Bedside report to the nurse
- Physician report
- Describe the patient's priority problem list, the treatment plan, and the treatment plan to the clinician
- Present cases to the clinician and fellow students for critique
- Focus on the linkages between the chief complaint (CC), history of CC, focused physical exam, and the associated pathology physiology

Reviewing assessments, skills and management of topics from Term 1 is useful to reinforce ACP scope of practice.

From Term 1:

- Applying and operating the monitor, including trouble shooting, defibrillation and synchronized Cardioversion
- Interpreting the ECG (3-lead)
- Assessing vital signs
- Starting IV's
- Preparing and administering all types of medications*
- Managing the airway, ventilation and oxygenation needs particular to the patient
- Performing systems-based physical assessment (including primary survey), and reporting their findings to you
- Recording findings and treatments on the patient care record form
- Accurately self evaluating their performance
- Seeking out, and receiving feedback in a professional manner

Also, as opportunities are encountered, please continue to validate competencies for:

- Endotracheal Intubation (ETI)
- Endotracheal Tube (ETT) Care
- ETT Suctioning
- Gastric Tube Insertion



- Peripheral IV Insertion
- Medication Administration
- Chest Tube Care
- Core Temperature Monitoring
- Tracheotomy Care
- Intracranial Pressure (ICP) Monitoring
- Central Venous Lines/Central Venous Pressure (CVP) Monitoring
- Pulmonary Artery (PA) Monitoring
- Infusion Pump
- Foley & Non-Catheterization Urinary Drainage Systems
- Ostomy Care
- Arterial Blood Gases (ABG) & Arterial Line Monitoring
- Defibrillation
- Synchronized Cardioversion
- Transcutaneous Pacing (TCP)
- Valsalva Maneuver
- Nasopharyngeal Airway
- Mechanical Ventilation

**See Appendix 7 for a list of NOCP Medications by ACP Program Term*

Term 3

At this time, the student has now received classroom instruction and clinical and field opportunities to for the assessment, diagnosis, and management of classic cases. In addition, students have completed NRP and Pediatric Protocols in Term 3. The focus of Term 3 is on 'complex' patient presentations.

The hospital sessions in Term 3 include:

- 1 day: OR (Optional) (1:1)
- 4 days: ER (4:1)
- 1 day: ERP (4:1)
- 1 day: Pediatrics/Neonatal (4:1)
- 1 day: ERP Shadow (1:1)

Term 3 is a time of subtle, but very significant transition from student to entry-level practitioner. It will sometimes be a tumultuous period. Most students do not make a linear transition; often there are periods where it seems to them and maybe you, that they can do no right! Be patient, focus on the basics, and where necessary, go back to the Term 2 process as a teaching technique to help the student improve. However, if you find that you are frequently instructing vs. coaching and mentoring, this is a hallmark finding for a student falling behind. Identify this with the student and advise the program faculty right away.

Training Plan - Term 3

Review the plan with the student. Clarify expectations for both the student and clinician.

New this Term:

- The student should be proficient in all of the competencies described in Terms 1 and 2. The focus should now be on applying the previously acquired skills in:
 - Evaluation of the patient with multi system dysfunction
 - Evaluation of maternity, neonate and pediatric patients
 - Assessing and presenting all cases including trauma, diabetes, overdose, poisoning, & environmental emergencies

This is also the last opportunity for the student to capture all of the required Clinical competencies. Please review the requirements each student requires in the following areas:

- Endotracheal Intubation (ETI)
- Endotracheal Tube (ETT) Care
- ETT Suctioning
- Gastric Tube Insertion
- Peripheral IV Insertion
- Medication Administration*
- Chest Tube Care
- Core Temperature Monitoring
- Tracheotomy Care
- Intracranial Pressure (ICP) Monitoring
- Central Venous Lines/ Central Venous Pressure (CVP) Monitoring
- Pulmonary Artery (PA) Monitoring
- Infusion Pump
- Foley & Non-Catheterization Urinary Drainage Systems
- Ostomy Care
- Arterial Blood Gases (ABG) & Arterial Line Monitoring
- Defibrillation
- Synchronized Cardioversion
- Transcutaneous Pacing (TCP)
- Valsalva Maneuver
- Nasopharyngeal Airway
- Mechanical Ventilation

**See Appendix 7 for a list of NOCP Medications by ACP Program Term*

Reviewing assessments, skills and management of topics from Terms 1 & 2 is useful to reinforce ACP scope of practice.

From Term 1 (Core Skills)

- Applying and operating the monitor, including trouble shooting, defibrillation and synchronized cardioversion
- Interpreting the ECG
- Assessing vital signs
- Starting IV's
- Preparing and administering all types of medications*
- Managing the airway, ventilation and oxygenation needs particular to the patient
- Performing systems-based physical assessments (including primary survey), and reporting their findings to you
- Recording findings and treatments on the patient care record form
- Accurately self evaluating their performance
- Seeking out, and receiving feedback in a professional manner

From Term 2

- Determine a patient's Chief Complaint
- Investigate cases using LOTARP/ PPPQRST
- Emphasis is for the student to stay focused on the history taking model and to LISTEN to the responses
- Determine the provisional/differential diagnosis
- Functional exam
- Bedside report to the nurse
- Physician report
- Describe the patient's priority problem list, and the treatment plan to the CWS provided in the log book. NOCP skills are determined after the patient encounter and submitted by the student to the Clinician on the CompTracker web site.
- Present cases to the clinician and fellow students for critique

**See Appendix 7 for a list of NOCP Medications by ACP Program Term*

Ambulance Practicum

Term 1

The objectives of Term 1 are for the student to experience the work of an Advanced Care Paramedic and to begin to apply their new skills and techniques in the ‘real world’. Students will be on-car for 2 to 3 blocks. The faculty responsible for monitoring the student will determine if the ‘extra’ block is necessary.

Many of the ACP students are PCP graduates with less than five years in the field and many have not worked in an ACP community. Simply locating all the ACP equipment in the ambulance may be a struggle. Many have never seen an ACP call, or worked alongside ACP. For many, the patient assessment model has changed. There are now different emphasis and linkages between history taking, physical exam, and the understanding of the pathophysiology.

The student must be afforded the opportunity to apply all ACP skills during the ambulance practicum. The student should be applying and operating the monitor while interpreting the 3-lead rhythm strip on every patient you assess. They should be performing all of the simple psychomotor skills (IV insertion, taking vital signs, drawing up and administering medications, etc.) on each call.

At the beginning of the block, you should be introducing the ACP Patient Assessment model for history taking and physical examination. Later in the block, they should be able to perform systems/ based assessment associated to the chief complaint.

Describe, Demonstrate and Do is a good profile of instruction to follow.

The student should be observing how you take the history, reach a diagnosis, and manage the call. This is the demonstration that will lead to ‘describe’ and ‘do’ in Term 2.

One of the most difficult transitions students experience at this point is the need to interact with EMAs (whom the student have considered a peer) in a wholly new manner. The ACP student is now receiving reports and beginning to delegate tasks to those whom they may have learned much from or worked alongside of, and may not feel comfortable with delegation to these co-workers.

Students can be overwhelmed with the new responsibilities associated with the ACP role. When the realism of ambulance calls is experienced and is added to the stressors as a student the result can be overwhelming.

Our goal in the classroom is to prepare the student for their future role in the field. They are taught each skill in isolation through the use of drills and simulations; sequencing is introduced and the student begins to assimilate the information to develop a differential diagnosis and

management plan. This is a time where you will need to work closely to guide the student through this period. Please remember that at this time the students are still leaning new skills and interpreting assimilating new knowledge. It is important to avoid judgemental comments and confuse them by suggesting short cuts and the use of “me-isms”. The student identifies very strongly with their preceptor and wants to please their preceptor.

At this time, your role is very similar to a classroom instructor. In later Terms, the preceptor gradually assumes the role of Coach and then Mentor with instructing opportunities becoming increasingly infrequent.

During Term 1 it is expected that the student is able to perform the ACP core skill components of all calls, but the **management of the patient** is the responsibility of the preceptor. To put it in simple terms, the student should start the block as an assistant to you in running the call, rather than them running the calls.

The only variation to this process should be cardiac arrest calls where the student should be able to formulate the treatment plan. Remember though that complex cardiac arrest management is not an expectation of Term 1.

Specifically we are looking for:

- Thorough systems-based patient assessment skills for history taking and physical examination
- The student to obtain the chief complaint, followed by the opportunity to explore the basic format of history taking based on the chief complaint. Information obtained at this point then starts the development of the differential diagnosis that is a direct reflection of the pathophysiology. From this point, the student can complete a comprehensive, system specific, physical assessment and seek clues from the physical examination to further explore the history. Once again remember that this is a very new skill and the student may take more time with their notes; developing thoroughness at this time is a preferable skill and encourages the students to develop good habits and a comprehensive skill set.
- Ability to incorporate ACP core skills into a field call
- Students to be able to perform all physical skills except intraosseous initiation
- Students who may not know ‘when’ or ‘why’ to perform a particular skill, but who should be able to ‘perform’ when instructed
- An ability to direct and implement the treatment plan for classic/uncomplicated cardiac arrests
- Interpersonal skills that includes appropriate communications and the ability to receive feedback

Training Plan - Term 1

Review the plan with the student. Get expectations clear for both the student and preceptor. Include your partner in the plan.

Demonstrate how you stock and clean the car, kits, and equipment. Expect the student to rapidly assume this role, with your supervision & assistance, at the start of each shift, as well as throughout the block.

On the first calls, demonstrate and describe how you manage each call. Involve them in an increasing manner as each call progresses.

The baseline should have the student:

- Applying and operating the monitor, including trouble shooting, defibrillation and synchronized cardioversion
- Interpreting the 3-lead rhythm strips
- Assessing vital signs
- Starting IV's
- Preparing and administering all types of medications*, as per their scope of practice
- Managing the airway, ventilation and oxygenation needs particular to the patient
- Observing how you take a history, build a differential diagnosis, and reach a diagnosis, implement the treatment plan, and manage all the aspects and participants in each call
- Demonstrating skills with preceptor supervision
- Performing basic history and systems-based physical assessment that includes the primary survey, starting with the chief complaint, and reporting their findings to you
- Recording findings and treatments on the patient care record
- Formulating and implementing the cardiac arrest treatment plan
- Accurately self evaluating their performance
- Seeking out, and receiving feedback in a professional manner

The primary focus for this Term is:

- Completing the “physical tasks”
- Managing cardiac arrest
- Using the ACP patient assessment model

**See Appendix 7 for a list of NOCP Medications by ACP Program Term*

Term 2

The Practicum in Term 2 is split into two parts: Part I takes place at the start of the Term and Part II takes place at the end of the Term.

Part I

The student has now learned, in the classroom and clinical environments, the assessment, diagnosis and management of ‘Classic’ Chest Pain, Shortness of Breath, Trauma and Collapse calls. It is a dynamic period of four blocks with escalating responsibilities for the student. This is likely the time that students will have the greatest difficulty implementing the many new assessment techniques and treatment modalities required.

Part II

Classroom topics include assessment, diagnosis and management of ‘Classic’ presentations of toxicological, mental health and medical cases involving the endocrine and immune systems, anaphylaxis, GI/GU, and environmental cases involving heat and cold and drowning and submersion. In addition, students have now completed classroom topics in Obstetrics/Maternity and PEPP. It is expected in that in Part II of the Practicum students will demonstrate a higher level of leadership and clinical decision making skills in call management than in Part I.

Please remember this is a generic template; some students progress quicker or slower. Customize this to best manage the student’s performance. If a student is ‘lagging’, please point this out to them and to the program staff.

This is likely the time that students will have the greatest difficulty implementing the many new assessment techniques while establishing a working differential and provisional diagnosis with treatment modalities. This is also a significant transition time for you and the student. The student assumes more responsibility, moving rapidly from the ‘Assistant’ to the ‘Conductor’ of the call. You move from the Conductor to the Coach position.

It is important that the student perform only those competencies for which they are responsible and have received training. It is our experience that if the student moves to new areas before mastering the basics, they never achieve acceptable competency. We recommend that the management of each patient should be ‘team’ oriented, with you as the captain, and the student undertaking more and more independence as they progress through the blocks.

Training Plan - Term 2

Focus on the following competencies:

New this Term

- Determine Chief Complaint
- Obtain history using an appropriate line of questioning based on the chief complaint. This is not unlike Term 1, but now we expect that the student has the basic framework and is able to thoroughly investigate the chief complaint.
- Investigate cases using LOTARP/ PPPQRST (Medical Director's medical model of patient assessment)
- Emphasis is for the student to stay focused on the history taking model and to LISTEN to the responses
- Take a history from a relative and through an appropriate line of questioning investigate to elicit missing information
- Functional exam
- Build a differential diagnosis and a working provisional diagnosis
- Call EP for orders as required
- Develop the priority problem list
- Formulate the treatment plan
- Implement/deliver the treatment plan (student should perform skills)
- Communicate treatment plan to family/ patient
- Manage/ organize/control/delegate scene responders, family, bystanders
- Organize transport
- Triage report
- Give a report to the physician
- Give the bedside report at the receiving hospital

From Term 1

- Applying and operating the monitor, including trouble shooting, defibrillation and synchronized Cardioversion
- Interpreting the 3-lead
- Assessing vital signs
- Starting IV's
- Preparing and administering all types of medications*
- Managing the airway, ventilation and oxygenation needs particular to the patient

- Participating in the process of building a working differential diagnosis reaching a provisional diagnosis, implement the treatment plan, and manage all the aspects and participants in each call
- Performing systems-based physical assessment (including primary survey) based on chief complaint and reporting their findings to you. It is always important that one drives the other and that it all links back to the underlying pathophysiology.
- Formulating and implementing the cardiac arrest treatment plan
- Recording findings and treatments on the patient care record
- Accurately self evaluating their performance
- Seeking out, and receiving feedback in a professional manner

By the end of their on-ambulance practicum, the student should now be assuming the full role of an ACP on all 'Classic' cases. Preceptor intervention in assessment and formulation/implementation of the treatment plan should become infrequent. We anticipate however that the student will still be depending on you to assist in the overall call management (managing, organizing, control and delegation to first responders, family, bystanders, and other crews).

**See Appendix 7 for a list of NOCP Medications by ACP Program Term*

Term 3

The student has learned (in the classroom, clinical and field environments) the assessment, diagnosis and management of classic cases. Term 3 classes and hospital practicums have focused on 'complex' patient presentations. In addition, students have completed NRP and Pediatric Protocols this term.

Precepting in Term 3 is a time of subtle, but very significant transition from student to entry level practitioner. It will sometimes be a tumultuous period. Most students do not make a linear transition - they move back and forth between the Terms and abilities to manage their new skills. Be patient, focus on the basics, and where necessary, go back to the Term 2 process as a teaching technique to allow the student to advance.

Training Plan - Term 3

Focus on the following competencies:

New this Term:

- Initiate intra-osseous infusions
- Determine the differential and working/ provisional diagnosis on complex medical and trauma calls.
- Develop the priority problem list
- Formulate the treatment plan
- Implement/deliver the treatment plan

From Terms 1 and 2:

- Good physical assessment skills
- Ability to incorporate ACP core skills into a field call
- Ability to manage cardiac arrest calls
- Determine Chief Complaint
- Investigate cases using LOTARP/ PPPQRST (Dr Ip's medical model of patient assessment)
- Emphasis is for the student to stay focused on the history taking model and to LISTEN to the responses
- Build a differential diagnosis
- Functional exam
- Bedside report from the nurse or relative
- Triage report
- Determine the working or provisional diagnosis
- Call EP for orders as required

- Physician report
- Develop the priority problem list
- Formulate the treatment plan
- Implement/ deliver the treatment plan
- Manage/ organize/ control/ delegate scene responders, family, bystanders
- Communicate treatment plan to family/ patient
- Organize transport
- Give the bedside report to both the nurse and ERP

The student should be assuming the full role of an ACP on all cases.

Preceptor intervention in assessment and formulation/implementation of the treatment plan should become infrequent. The goal to achieve is that you are in the background more and more. The patient should not require your assistance. The responding crews and other agencies should be focused on the student for direction. If you find that you are instructing vs. coaching and mentoring, this is a hallmark finding of a student falling behind the curve. Identify this with the student and advise the faculty right away. The student needs this identified and corrected right away. Ensure all corrective feedback is noted on the competency management system.

Useful links

1. **CompTracker:**
www.studentlogbook.com
2. **EMA licensing to see the complete regulation that includes the scope of practice for EMR, PCP, ACP, and CCP practitioners.**
www.health.gov.bc.ca/ema/
3. **Justice Institute of BC new Teaching and Learning Center, for faculty**
www.jibc.ca/programs-courses/graduate-studies-academic-services/faculty-support
4. **School of Health Sciences: Clinician and Preceptor Newsletter – PARAgaph (archives for all issues)**
www.jibc.ca/programs-courses/schools-departments/school-health-sciences/paragraph-archives
5. **BC Academic Council – Practice Education Guidelines**
www.practiceeducation.org
6. **Paramedic Association of Canada**
www.paramedic.ca

APPENDICES

Appendix 1.....ACP National Occupational Competency Profile (NOCP)
Appendix 2Skills and Procedures
Appendix 3Scope of Practice - EMALB
Appendix 4CompTracker
Appendix 5Work Related Injury
Appendix 6.....Sample PCR and CWS
Appendix 7.....NOCP Medication List by Term
Appendix 8.....BCAS Patient Privacy Policy

Appendix 1: ACP National Occupational Competency Profile

ACP - NOCP On-Ambulance Competencies
Professional Responsibilities
<p>1.1 Function as a professional.</p> <ul style="list-style-type: none"> 1.1.a Maintain patient dignity. 1.1.b Reflect professionalism through use of appropriate language. 1.1.c Dress appropriately and maintain personal hygiene. 1.1.e Maintain patient confidentiality. 1.1.h Promote awareness of emergency medical system and profession. 1.1.j Behave ethically. 1.1.k Function as patient advocate. <p>1.3 Possess an understanding of the medicolegal aspects of the profession.</p> <ul style="list-style-type: none"> 1.3.a Comply with scope of practice. 1.3.c Include all pertinent and required information on ambulance call report forms. <p>1.5 Function effectively in a team environment</p> <ul style="list-style-type: none"> 1.5.a Work collaboratively with a partner. 1.5.b Accept and deliver constructive feedback. 1.5.c Work collaboratively with other emergency response agencies. 1.5.d Work collaboratively with other members of the health care team. <p>1.6 Make decisions effectively.</p> <ul style="list-style-type: none"> 1.6.a Exhibit reasonable and prudent judgement. 1.6.b Practice effective problem-solving. 1.6.c Delegate tasks appropriately.
Communication
<p>2.1 Practice effective oral communication skills.</p> <ul style="list-style-type: none"> 2.1.a Deliver an organized, accurate and relevant report utilizing telecommunication devices. 2.1.b Deliver an organized, accurate and relevant verbal report. 2.1.c Deliver an organized, accurate and relevant patient history. 2.1.d Provide information to patient about their situation and how they will be treated. 2.1.e Interact effectively with the patient, relatives and bystanders who are in stressful situations. 2.1.f Speak in language appropriate to the listener. 2.1.g Use appropriate terminology. <p>2.2 Practice effective written communication skills.</p> <ul style="list-style-type: none"> 2.2.a Record organized, accurate and relevant patient information. <p>2.3 Practice effective non-verbal communication skills.</p> <ul style="list-style-type: none"> 2.3.b Practice active listening techniques. 2.3.c Establish trust and rapport with patients and colleagues. 2.3.d Recognize and react appropriately to non-verbal behaviours.



2.4 Practice effective interpersonal relations.

2.4.a Treat others with respect.

2.4.b Exhibit empathy and compassion while providing care.

2.4.c Recognize and react appropriately to individuals and groups manifesting coping mechanisms.

2.4.d Act in a confident manner.

2.4.e Act assertively as required.

2.4.f Manage and provide support to patients, bystanders and relatives manifesting emotional reactions.

2.4.g Exhibit diplomacy, tact and discretion.

Health and Safety

3.1 Maintain good physical and mental health.

3.1.e Exhibit physical strength and fitness consistent with the requirements of professional practice.

3.2 Practice safe lifting and moving techniques.

3.2.a Practice safe biomechanics.

3.2.b Transfer patient from various positions using applicable equipment and / or techniques.

3.2.d Secure patient to applicable equipment.

3.2.e Lift patient and stretcher in and out of ambulance with partner.

3.3 Create and maintain a safe work environment.

3.3.a Assess scene for safety.

3.3.b Address potential occupational hazards.

3.3.f Practice infection control techniques.

3.3.g Clean and disinfect equipment.

3.3.h Clean and disinfect an emergency vehicle.

Assessment and Diagnostics / Pathophysiology

4.2 Obtain patient history.

4.2.a Obtain list of patient's allergies.

4.2.b Obtain list of patient's medications.

4.2.c Obtain chief complaint and / or incident history from patient, family members and / or bystanders.

4.2.d Obtain information regarding patient's past medical history.

4.2.e Obtain information about patient's last oral intake.

4.2.f Obtain information regarding incident through accurate and complete scene assessment.

4.3 Conduct complete physical assessment demonstrating appropriate use of inspection, palpation, percussion and auscultation, and interpret findings.

4.3.a Conduct primary patient assessment and interpret findings.

4.3.b Conduct secondary patient assessment and interpret findings.

4.3.c Conduct cardiovascular system assessment and interpret findings.

4.3.d Conduct neurological system assessment and interpret findings.

4.3.e Conduct respiratory system assessment and interpret findings.

4.3.g Conduct gastrointestinal system assessment and interpret findings.

4.3.h Conduct genitourinary system assessment and interpret findings.

4.3.j Conduct musculoskeletal assessment and interpret findings.

4.3.k Conduct assessment of the immune system and interpret findings.



- 4.3.l Conduct assessment of the endocrine system and interpret findings.
- 4.3.n Conduct multisystem assessment and interpret findings.
- 4.4 Assess vital signs.
 - 4.4.a Assess pulse.
 - 4.4.b Assess respiration.
 - 4.4.d Measure blood pressure by auscultation.
 - 4.4.e Measure blood pressure by palpation.
 - 4.4.g Assess skin condition.
 - 4.4.h Assess pupils.
 - 4.4.i Assess level of mentation.
- 4.5 Utilize diagnostic tests.
 - 4.5.c Conduct glucometric testing and interpret findings.
 - 4.5.l Conduct 3-lead electrocardiogram (ECG) and interpret findings.

Therapeutics / Medications

- 5.2 Prepare oxygen delivery devices.
 - 5.2.e Utilize portable oxygen delivery systems.
- 5.5 Implement measures to maintain hemodynamic stability.
 - 5.5.c Maintain peripheral intravenous (IV) access devices and infusions of crystalloid solutions without additives.
 - 5.5.d Conduct peripheral intravenous cannulation.
- 5.6 Provide basic care for soft tissue injuries.
 - 5.6.a Treat soft tissue injuries.
- 5.7 Immobilize actual and suspected fractures.
 - 5.7.b Immobilize suspected fractures involving axial skeleton.
- 5.8 Administer medications.
 - 5.8.b Follow safe process for responsible medication administration.
 - 5.8.e Administer medication via intravenous route.

Integration

- 6.1 Utilize differential diagnosis skills, decision-making skills and psychomotor skills in providing care to patients.
 - 6.1.a Provide care to patient experiencing illness or injury primarily involving cardiovascular system.
 - 6.1.b Provide care to patient experiencing illness or injury primarily involving neurological system.
 - 6.1.c Provide care to patient experiencing illness or injury primarily involving respiratory system.
 - 6.1.e Provide care to patient experiencing illness or injury primarily involving gastrointestinal system.
 - 6.1.f Provide care to patient experiencing illness or injury primarily involving integumentary system.
 - 6.1.g Provide care to patient experiencing illness or injury primarily involving musculoskeletal system.
 - 6.1.k Provide care to patient experiencing illness or injury due to poisoning or overdose.
 - 6.1.l Provide care to patient experiencing non-urgent medical problem.
 - 6.1.o Provide care to patient based on understanding of common physiological, anatomical, incident and patient-specific field trauma criteria that determine appropriate decisions for triage, transport and destination.

- 6.1.p Provide care for patient experiencing psychiatric crisis.
- 6.3 Conduct ongoing assessments and provide care.
- 6.3.a Conduct ongoing assessments based on patient presentation and interpret findings.
- 6.3.b Re-direct priorities based on assessment findings.

Transportation

- 7.1 Prepare ambulance for service.
- 7.1a Conduct vehicle maintenance and safety check.



ACP - NOCP Clinical Competencies

Assessment and Diagnostics / Pathophysiology

- 4.3 Conduct complete physical assessment demonstrating appropriate use of inspection, palpation, percussion and auscultation, and interpret findings.
 - 4.3.f Conduct obstetrical assessment and interpret findings.
 - 4.3.o Conduct neonatal assessment and interpret findings.
- 4.4 Assess vital signs.
 - 4.4.c Conduct non-invasive temperature monitoring.
 - 4.4.f Measure blood pressure with non-invasive blood pressure monitor.
- 4.5 Utilize diagnostic tests.
 - 4.5.a Conduct oximetry testing and interpret findings.
 - 4.5.b Conduct end-tidal carbon dioxide monitoring and interpret findings.

Therapeutics / Medications

- 5.1 Maintain patency of upper airway and trachea.
 - 5.1.a Use manual maneuvers and positioning to maintain airway patency.
 - 5.1.b Suction oropharynx.
 - 5.1.c Suction beyond oropharynx.
 - 5.1 d Utilize oropharyngeal airway.
 - 5.1.h Utilize airway devices requiring visualization of vocal cords and introduced endotracheally.
- 5.3 Administer oxygen
 - 5.3.a Administer oxygen using nasal cannula.
 - 5.3.d Administer oxygen using high concentration mask.
- 5.4 Utilize ventilation equipment.
 - 5.4.a Provide oxygenation and ventilation using bag-valve-mask.
 - 5.4.d Provide mechanical ventilation.
- 5.5 Implement measures to maintain hemodynamic stability.
 - 5.5.o Provide routine care for patient with urinary catheter.
- 5.8 Administer medications.
 - 5.8.c Administer medication via subcutaneous route.
 - 5.8.d Administer medication via intramuscular route.
 - 5.8.h Administer medication via sublingual route.
 - 5.8.j Administer medication via oral route.
 - 5.8.l Administer medication via inhalation.



Integration

- 6.1 Utilize differential diagnosis skills, decision-making skills and psychomotor skills in providing care to patients.
 - 6.1.q Provide care for patient in labour.
- 6.2 Provide care to meet the needs of unique patient groups.
 - 6.2.a Provide care for neonatal patient.
 - 6.2.b Provide care for pediatric patient.
 - 6.2.c Provide care for geriatric patient.

Appendix 2: Skills and Procedures

Advanced Care Paramedic - Clinical and Field Guide to Skills and Procedures

Index

1. Physical Assessment
2. History Taking
3. Endotracheal Intubation (ETI)
4. Endotracheal Tube (ETT) Care
5. ETT Suctioning
6. Gastric Tube Insertion
7. Peripheral IV Insertion
8. Medication Administration*
9. Chest Tube Care
10. Core Temperature Monitoring
11. Tracheotomy Care
12. Intracranial Pressure (ICP) Monitoring
13. Central Venous Lines/Central Venous Pressure (CVP) Monitoring
14. Pulmonary Artery (PA) Monitoring
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17. Ostomy Care
18. Arterial Blood Gases (ABG)/Arterial Line Monitoring
19. Laboratory and Radiological Data
20. 12-Lead ECG
21. Mechanical Ventilation
22. Defibrillation
23. Synchronized Cardioversion
24. Transcutaneous Pacing (TCP)
25. Valsalva Maneuver

**See Appendix 7 for a list of NOCP Medications by ACP Program Term*



1. Physical Assessment:

The student adhered to the following objectives:

- Notes patient's state of awareness, state of health, posture, personal hygiene, speech patterns

Inspects/palpates head and neck including:

- Pupils
- Mouth (central Cyanosis)
- Neck for symmetry, masses
- Tracheal Position
- Assesses for JVD
- Palpates carotid pulse

Inspects/palpates chest including:

- Notes rate, rhythm and effort of breathing
- Inspects chest for symmetry, use of accessory muscles, retraction or evidence of trauma
- Palpates chest for areas of tenderness, stability of rib cage, degree of respiratory excursion
- Auscultate lungs for air entry (EQUAL) normal/abnormal breath sounds
- Assess apical pulse

Inspects abdomen:

- Auscultate bowel sounds in all 4 quadrants to assess bowel motility
- Palpates abdomen lightly for presence of masses, muscular resistance or abdominal tenderness

Inspects/palpates extremities including:

- Palpates femoral pulses
- Inspects lower extremities for edema or evidence of peripheral vascular disease
- Palpates lower extremities noting abnormal movement or tenderness, temperature of limbs, capillary refill in nail beds
- Palpates pedal pulses
- Assesses sensation and motor strength in both extremities

Inspects/palpates back including:

- Assesses for any deformities or tenderness
- Palpates for sacral edema

CARDIO, RESP, NEURO, GI/GU SPECIFIC CONSIDERATIONS

Head and neck	CVS: JVD, Pulsations, Cannon waves RESP: Stoma sounds NEURO: Facial droop, Voice GI/GU: Swallow reflex
Chest	CVS: Heart sounds, S1/S2, Abnormal sounds RESP: Tracheal, Bronchial, Fine rales, Med rales, Coarse rales, Abnormal sounds, Location of sound, Tactile Fremitus, Percussion NEURO: Sensation
Abdomen	CVS: Aneurysm RESP: Diaphragm breathing NEURO: Skin sensation, Incontinence GI/GU: Rebound tenderness
Extremities	CVS: Peripheral Vascular disease, Capillary refill, Pedal pulses, Edema, Cyanosis RESP: Edema, Cyanosis, Nail Clubbing NEURO: Sensation, Weakness
Back	RESP: Auscultate all lobes CVS: Sacral edema



2. History Taking:

The student adhered to the following objectives:

Primary survey component

- Introduces themselves in a reassuring manner and encourages the patient to relax

History component

- Determines the chief complaint
- Determines the history of the chief complaint using an organized approach (LOTAARP)
 - Location of pain/Does it radiate
 - Onset of chief complaint (time, acute, chronic)
 - Type of pain (description)
 - Associated-symptoms
 - Aggravating-Does anything make the chief complaint worse
 - Relief-Does anything relieve the chief complaint?
 - Precipitating-What patient was doing at the time of onset?
 - **Previous- has the chief complaint happened before/Compare to previous episodes**

Past medical history

- Other medical problems, past or present
- Previous hospitalizations
- Recent diagnostic investigations
- Recent visits to family doctor
- Systems Inquiry

Medications

- Dosage/frequency
- Compliance
-

Allergies

- List, type of reaction

Functional inquiry

- General health recently (e.g. past few days or weeks)
- Determines if patient has other symptoms, complaints not directly related to chief complaint (CVS, RESP, NEURO, GI/GU, ENDO, SKIN)

3. Endotracheal Intubation (ETI):

The student adhered to the following objectives:

- The attendant uses aseptic technique and universal precautions throughout procedure
- Assembles and prepares necessary equipment
 - Checks light
 - Selects appropriately sized tube
 - Checks cuff inflation
 - Inserts stylette guide if required
 - Lubricates distal end of tube
 - Maintains sterility of tube throughout procedure
- Pre-oxygenates patient
 - Monitors patient's SpO₂
- Positions the patient appropriately
- Inserts laryngoscope into mouth and exposes vocal chords
 - Using left hand, inserts into the right side of the mouth
 - Pushes tongue to the left
- Suctions as required (may do this step earlier)
- Inserts endotracheal tube into trachea
 - Using right hand, inserts the tube into right side of mouth
 - Visualizes cuff passing vocal chords
- Checks tube distance against teeth
- Inflates cuff to sufficient volume
- Ventilates patient and confirms tube placement
 - Visual, chest rise and fall, tube misting, compliance, auscultation, PetCO₂
- Secures endotracheal tube
- Resumes ventilation of patient (at no time is patient at risk of hypoxia due to prolonged procedure)

- Positions blade correctly (according to type)

4. Endotracheal Tube (ETT) Care:

The student adhered to the following objectives:

- The attendant uses aseptic technique and universal precautions throughout procedure
- Verifies tube position
- Secures ET Tube
- Correctly adjusts tube if needed
- Checks inflated cuff pressure
- Monitors ET Tube for misting and secretions
- Reconfirms tube placement after each movement of patient

5. Endotracheal Tube Suctioning:

The student adhered to the following objectives:

- | | |
|--|---|
| <ul style="list-style-type: none"> • The attendant uses aseptic technique and universal precautions throughout procedure • Ensure need by auscultation • Note vital signs • Appropriate selection of equipment • Position patient • Allow for adequate chest expansion • Ensure connection/assembly of all equipment <ul style="list-style-type: none"> • Catheter to suction, maintain sterility, keep tip in tubing • Maintain sterile technique • Pull out catheter and wrap end around gloved hand • Maintain sterility throughout process • Pinch catheter and check suction pressure • Should be between 80-120 mm/kg • Pre-oxygenate patient <ul style="list-style-type: none"> • FiO₂ 1.0, SpO₂ | <ul style="list-style-type: none"> • Remove ventilator and advance catheter down ET Tube to carina and stop advancing (do not apply suction while inserting catheter) • Withdraw catheter about 1 cm and apply suction while withdrawing and rotating catheter <ul style="list-style-type: none"> • Rolling and withdrawing tends to cause fluid to following up with your catheter • From catheter insertion to withdrawal should take no more than 15 seconds (to protect patient from becoming hypoxic) • Remove catheter, ventilate patient at FiO₂ 1.0 • Assess for signs of hypoxia • Assess effects of suctioning, repeat if necessary (suction again if necessary) • Reset oxygen flow rate (to patient's parameters) • Pull glove off so catheter is inside and discard <ul style="list-style-type: none"> • Ensure catheter disposed of to prevent cross contamination |
|--|---|



- Record and document any abnormalities
 - Colour, blood, abnormal odor

6. Gastric Tube Insertion:

The student adhered to the following objectives:

- The attendant uses aseptic technique and universal precautions throughout procedure
- Lists indications
 - Cardiac Arrest
 - Gastric distention interfering with ventilation
- Assembles and prepares equipment needed
 - Nasogastric tube (14 of 16f), Water-soluble lubricating jelly, Laryngoscope, 30-50ml syringe, Stethoscope, Tape, Gloves
- Estimates distance
 - Distance from stomach to nose extending down to earlobe
- Lubricates tube
 - Lubricates 7.5-10 cm of tube with water soluble lubricant
- Visualizes the esophagus (Orogastric)
- Inserts tube, advances tube to desired distance
- Checks tube placement
 - Connects syringe to tube
 - Places stethoscope over upper left quadrant of patient's abdomen just below costal margin
 - Injects 10-20ml of air while auscultating – whooshing sound to confirm tube placement
- If tube is not in stomach, advances another 2.5-5 cm and rechecks position
- Anchors tube with tape

7. Peripheral IV Initiation:

The student adhered to the following objectives:

- The attendant uses aseptic technique and universal precautions throughout procedure
- The attendant prepares the solution bag:
 - Correct solution
 - Checks protective bag for leaks and foreign bodies
 - Checks solution for leaks, cloudiness, discoloration, precipitate or foreign bodies
 - Checks expiry date
- The attendant prepares the administration set:
 - Correct set
 - Checks tubing for discoloration, kinks, damage
 - Position roller clamp near drip chamber and close clamp
- The attendant prepares the IV set:
 - Invert bag and remove the tab
 - The attendant gathers and prepares equipment (tape, appropriate catheter, OpSite, alcohol swabs).
 - The attendant prepares the insertion site.
 - The attendant inserts the catheter using acceptable technique.
 - The attendant immediately places all sharps in an acceptable sharps container.
 - The attendant connects the tubing to the catheter and opens roller clamp slowly, ensuring the IV has not gone interstitial
 - The attendant sets the IV at an appropriate rate
 - The attendant secures the catheter and tubing
 - The attendant ensures that all litter is gathered and properly disposed of.

- Remove cap from tubing spike and insert into bag
- Fill drip chamber to ~ ½ full
- Run solution through tubing, ensuring that there are no air bubbles

8. Medication Administration:

The student adhered to the following objectives:

- The attendant uses aseptic technique and universal precautions throughout procedure
- Verifies order
 - Ensure correct medication/solution
- Correctly calculates drug dosage
 - Correctly determines volume of drug to administrator
- Selects the right medication
 - Uses 5 “R’s” (ensures correct medication, checks expiration date)
- Selection and preparation of equipment
- Correctly withdraws medication dose
 - From ampoules, multi-dose vials
- Identification of patient
 - Uses 5 “R’s” (ensures correct patient, confirm allergies)
- Uses aseptic technique
 - Maintains sterility throughout process
 - Cleans site per hospital policy
- Administers correct medication dosage
 - Uses 5 “R’s”
- Correctly disposes of all sharps
 - Does not recap needles/uses sharps containers
- Assesses patient response
- Documents medication administration
 - Medication, dose, time, route, initial

Subcutaneous/IM Medication

- Exposes site
- Preps site
- Inserts needle 45 degrees (SC)
- Inserts needs 90 degrees (IM)
- Aspirates for blood
- Injects medication
- Massages site

IV Medication

- Preps portal
- Pinches line
- Injects medication
- Disposes of sharp
- Flushes medication
- Resets correct drip rate

Piggyback Medication

- Mixes correct concentration
- Preps portal
- Inserts piggyback needle into portal
- Sets drip rate of piggyback IV
- Turns off main medical IV

Inhaled/Nebulised Medication

- Mixes correct concentration
- Sets air/oxygen flow rate correctly

ETT Medication

- Mixes correct concentration
- Injects medication into ET tube
- Occludes end of ET tube
- Ventilates 3-5 breaths to distribute medication

9. Chest Tube Care:

The student adhered to the following objectives:

- Identifies the purpose of and indications for chest tube insertion
 - Clinically significant pneumothorax, hemothorax
 - Preflight: any hemo/pneumothorax, multiple rib fractures, pulmonary contusion
- Identifies the equipment required to care for a chest tube
 - Waterproof tape, chest tube clamps x 2, pleurovac, Heimlich valve (if no pleurovac)

10. Core Temperature Monitoring:

The student adhered to the following objectives:

- Differentiates between core and peripheral temperature monitoring
- States the indications for core temperature monitoring
 - Moderate to severely hypothermic patients

11. Tracheotomy Care:

The student adhered to the following objectives:

- Identifies the purposes of a tracheotomy
- Explains the care required of a patient with a tracheotomy

12. Intracranial Pressure (ICP) Monitoring:

The student adhered to the following objectives:

- Defines intracranial pressure
 - Pressure exerted by the intracranial contents (blood, brain, cerebro-spinal fluid)
 - Normal is less than 15 mm Hg, 20-40 is Moderate, >40 is Severe; Cough/strain can elicit rises up to 100 mm Hg
- States the indications for ICP monitoring

13. Central Venous Lines/Central Venous Pressure (CVP) Monitoring:

The student adhered to the following objectives:

- Lists the indications for central line access
 - Patients in whom IV access is required and peripheral access is insufficient or not available
 - For hemodynamic monitoring
- Lists common sites for central line insertion
 - Femoral, subclavian, internal jugular veins
- Defines central venous pressure
 - Pressure within the right atrium
 - Normal is 0-6 mm Hg
- Lists the indications for CVP monitoring
 - Hemodynamically unstable or potentially unstable patient's (shock, CHF)
 - Multiple vasocactive/inotropic pharmacologic support
 - For diagnostic purposes

14. Pulmonary Artery (PA) Monitoring:

The student adhered to the following objectives:

- Defines PA catheter monitoring
 - Measures pressure within the pulmonary artery via catheter inserted through the right atrium/ventricle
- Lists the indications for PA monitoring
 - Hemodynamically unstable or potentially unstable patient's (shock, CHF)
 - For diagnostic purposes

15. Infusion Pump:

The student adhered to the following objectives:

- Lists the indications for the use of an infusion pump
- Troubleshoots a common pump

16. Foley Catheterization and Non-Catherization Urinary Drainage Systems:

The student adhered to the following objectives:

- Identifies the indications for, purpose of and required equipment for urinary catheterization and non-catheter urinary drainage
 - Inability to urinate
 - Patient's in whom urine output must be monitored
- Explains how the size of the catheter can affect the patient
- Describes the differences to catheterization of males and females
- Explains the relationship between urine output and patient condition
- Performs appropriate technique when caring for equipment and a patient
- Explains potential complications to catheter care
 - Infection, sepsis
- Demonstrates how to drain and measure urine output

17. Ostomy Care:

The student adhered to the following objectives:

- Identifies the purpose of and equipment required for an ostomy drainage system
- Explains the site of the ostomy and relate to patient condition
- Demonstrates routine care for patient with an ostomy drainage system

18. Arterial Blood Gases (ABG)/Arterial Line Monitoring:

The student adhered to the following objectives:

- Lists the indications for ABG sampling
 - Patient's requiring assessment of ventilatory and oxygenation status

- COPD, Ventilated patients, smoke inhalation, burns, respiratory failure, ARDS....
- Identifies sites to sample an ABG
 - Radial and femoral
- Defines arterial pressure
 - Pressure generated within blood vessels as the force of blood flow from the heart meets resistance in the vessels
- Lists the indications for arterial line monitoring
 - Serial assessment of ABG's
 - Hemodynamically unstable or potentially unstable patient's (shock, CHF)
 - Multiple vasocactive/inotropic pharmacological support
 - For diagnostic purposes

19. Laboratory and Radiological Data:

The student adhered to the following objectives:

- Identifies examples of common laboratory and radiological data
 - Stress test, Echocardiogram, Cardiac catheterisation, MIBI Scan
 - Cardiac Enzymes: CK, CK-MB, LGH, AST Troponin
 - Electrolytes: Na, K, Cl, HCO₃, Ca, Mg, HPO₄
 - CBC: HgB, Hct, WBC
 - Chest X-ray
 - Urinalysis

20. 12-lead ECG:

The student adhered to the following objectives:

- Explains the difference between a 3-lead and a 12-lead ECG
 - 3 lead is a monitoring device
 - 12 lead to interpret changes in the direction of electrical forces associated with bundle branch blocks, hemiblocks, arrhythmia's, ischemia and infarction
- Identifies the indications for use of a 12-lead ECG
 - Diagnostics

21. Mechanical Ventilator:

The student adhered to the following objectives:

- **Recognizes the indications for mechanical ventilation**
 - Define mechanical ventilation
 - Identify the various types of mechanical ventilation equipment
 - Discuss indications for mechanical ventilation

- **Prepares mechanical ventilation equipment**
 - Discuss potential complications and safety issues when using mechanical ventilators
 - Describe vent circuit, end-tidal carbon dioxide, manometer, and respirometer
 - Differentiate between intermittent mandatory ventilation (IMV), continuous mandatory ventilation (CMV), assist control (AC), inverse ratio
 - Discuss continuous positive airway pressure, positive end-expiratory pressure, and non-invasive positive pressure ventilation
 - Describe blender, saturated oxygen
 - Describe compliance, resistance, plateau pressure, inspiratory pressure, expiratory pressure, peak expiratory pressure, tidal volume, respiratory rate
 - Set up mechanical ventilator based on patient presentation

- **Provides mechanical ventilation**
 - Demonstrate use of mechanical ventilator based on patient presentation
 - Adjust parameters to changes in ventilatory and hemodynamic changes
 - Integrate the use of mechanical ventilator based on patient presentation
 - Integrate the use of PetCO₂ monitoring

22. Defibrillation:

The student adhered to the following objectives:

- List the indications for defibrillation
 - V/F, Pulseless Wide Complex Tachycardia (WCT) and Pulseless Narrow Complex Tachycardia (NCT)
- Apply electrode gel to paddles/applies hands free patches appropriately
- Set the defibrillator to appropriate energy level and charges unit
- Assess monitor and patient for a change in rhythm and pulse
- **Ensure no pulse before continuing**



- Has CPR discontinued and places paddles on the patient's chest with sufficient pressure to minimise impedance
- Ensure that no one is in contact with patient and warns other rescuers stating "clear"
 - Visual check of patient to ensure no one is in contact before defibrillation
- Depress the paddle buttons and delivers shock to the patient
- Assess monitor for a change in rhythm
- Deliver subsequent shocks at appropriate energy levels so long as patient's rhythm does not change.
- Assess the monitor for a change in rhythm as well as checking the patient for a pulse.
- Ensure that CPR is resumed.
- Deliver further defibrillations as indicated using appropriate energy levels with good technique.

23. Synchronized Cardioversion:

The student adhered to the following objectives:

- Lists the indications for Synchronized Cardioversion
 - Symptomatic WCT and NCT
- Applies electrode gel to paddles/applies hands free patches appropriately
- Selects **SYNC**
 - Ensure R waves are flagged
- Set the defibrillator to appropriate energy level and charges unit
- Assess monitor and patient for change in rhythm and pulse
- Place paddles on the patient's chest with sufficient pressure to minimize impedance
- Ensure that no one is in contact with patient and warns other rescuers stating "clear"
 - Visual check of patient to ensure no one is in contact before cardioversion
- Depress the paddle buttons, holds until the shock is delivered to the patient
- Assess patient
- Delivers further cardioversions as indicated using appropriate energy levels with good technique.

24. Transcutaneous Pacing (TCP):

The student adhered to the following objectives:

- Lists the indications for TCP
 - Symptomatic Bradycardia and Cardiac Arrest responsive to Fist Pacing
- Applies hands free patches appropriately (Anterior-Lateral or Anterior-Posterior)
- Turns **PACER** on
- Sets pacer rate (~70)
- Increases energy level by 20 mA until **Electrical Capture**
- Assesses **Mechanical Capture**
 - Pulse, heart sounds, blood pressure, SpO₂, PetCO₂
 - If no mechanical capture after electrical, search for other causes
- After electrical and mechanical capture, increase mA by 10 %
- Assess patient

25. Valsalva Maneuver:

The student adhered to the following objectives:

- List the indications for performing a Valsalva Maneuver
 - Symptomatic NCT (rate greater than 160 bpm)
- Ensure the patient is semi fowlers on the stretcher (or equivalent)
- Instruct the patient to:
 - Take a breath and hold it
 - Bear down against closed glottis as long as they are able
 - Exhale as forcefully as possible
- While the patient is exhaling, lay patient supine, preferably elevate legs
- Assess monitor and patient for effect

Appendix 3: Scope of Practice - EMALB

Schedule 1 **[am. B.C. Reg. 207/2006, ss. 2 and 3.]**

Services – Licence Category

PCP

- All services specified in this Schedule and Schedule 2 for the category of EMR;
- Administration of the following intravenous, oral, sublingual, subcutaneous, inhaled, intra-muscular or nebulized medications;
 - Narcotic antagonist
 - Bronchodilator
 - Anti-histaminic
 - Sympathomimetic agent

ACP

- All services specified in this Schedule and Schedule 2 for the category of PCP;
- Electrocardiogram rhythm interpretation, cardioversion, external pacing, and manual defibrillation;
- Initiation and maintenance of intraosseous needle cannulation;
- Nasopharyngeal airway;
- Maintenance of intravenous routes using intermittent infusion devices, including IV pumps;
- Initiation of external jugular vein cannulation;
- Cricothyrotomy and needle thoracentesis;
- Gastric intubation and suction;
- Maintenance of intravenous lines with medications;
- Insertion and maintenance of advanced airway devices which do not require laryngoscopy;
- Use and interpretation of end tidal CO₂ monitoring devices;
- Administration of colloid and non-crystalloid volume expanders;
- Administration of the following intravenous, oral, nebulized, endotracheal, intraosseous, intramuscular and rectal medications;
 - Anti-arrhythmic
 - Electrolyte – calcium therapy
 - Diuretic
 - Anti-coagulant
 - Narcotic
 - Anti-pyretic
 - Anti-cholinergic
 - Sedative
 - Anti-emetic – anti-nauseant
 - Histamine antagonist
 - Anti-convulsant
 - Alkalizer

Schedule 2
[am. B.C. Reg. 207/2006, ss. 4 and 5.]

Services – Licence Endorsement

PCP

- initiation of peripheral intravenous lines
- administration of the following intravenous fluids and medications
 - anti-hypoglycemic agent,
 - isotonic crystalloid solutions, or
 - Vitamin B1
- Endotracheal intubation.

ACP

- Mechanical ventilation;
- Administration of drug therapy on the direct order of a medical practitioner who is designated by an employer as a Transport Advisor;
- Urinary catheterization
- Arterial line management and central venous pressure monitoring
- Infusion of blood products
- Point of care testing using capillary, venous, or arterial sampling;
- Collect arterial and venous blood samples;
- Interpret laboratory and radiologic data;
- Perform and interpret 12 lead electrocardiograph;
- Chest tube management;
- Central line management;
- Management of parenteral feeding lines and equipment;
- Provide trans-venous pacing.



Appendix 4: CompTracker

Quick Start Guide: Online approvals



COMPTRACKER® Version 5.0
SOLUTIONS FOR MODERN LEARNING

For more CompTracker training materials, go to www.studentlogbook.com/Training

Quick Start Guide: ONLINE APPROVALS

1 Login: Go to www.studentlogbook.com. Click on the blue "login" button, then enter your login credentials to approve data that's been assigned to you by your students.

2 All the Pending items that are assigned to you are identified in the top left corner of the website under the "My Activities" box. Anything with a number and a link means that you have pending data. Click the links to bring up the information and review it.

3 Pending Attendance

Click on a student's name on the left side to see all Attendance records. Click on the square to confirm approval of each shift, or use the header checkmark to mark all as **Approved**.
"Recall" any items that shouldn't be counted for this student. Edit any of the times by clicking on the clock icon. Type your name in the signature area, then click on "Sign & Close" to approve the records.

4 Pending Forms

Click on a student's name on the left side to see all forms. Complete any fields on the form that are marked with a red asterisk (*), they are required. If competencies are attached, see the next step for Pending Competencies as it is the same process. If applicable, you may add more competencies to this form using "Add Competencies."

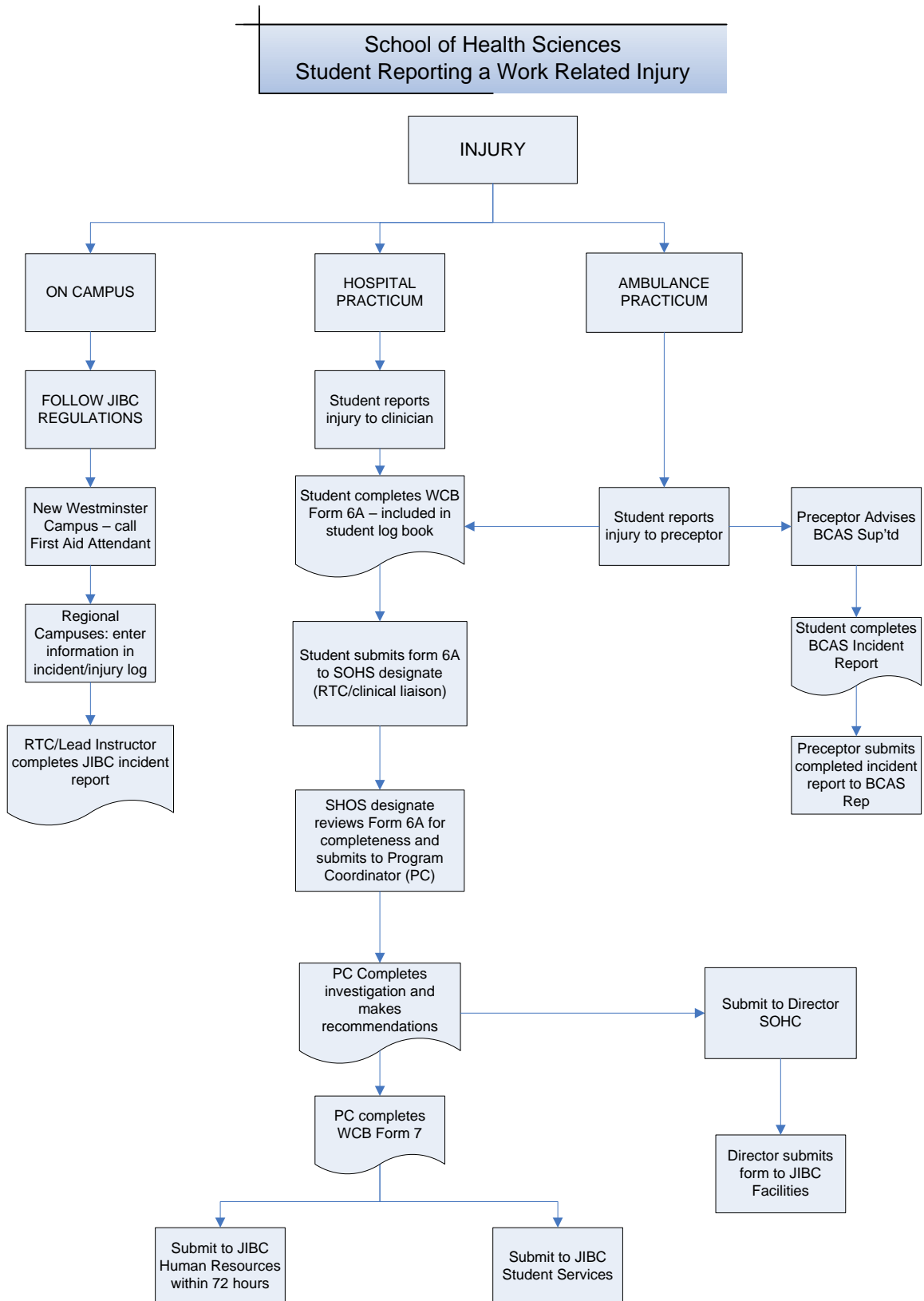
5 Pending Competencies

Mark the competencies all "Approved" or all "Not Approved" using the header checkmark or X in each Area. To approve them one at a time click the grey square beside the competency once to Approve it and a second time to mark it Not Approved.
"Recall" any items that were not attempted.
Complete any fields within the competency that are marked with a red asterisk (*), they are required. Add comments as applicable, they may also be required. "Copy to All" will paste the same comment in all competencies with the same status (of Approved or Not Approved). Type your name in the signature area, then click on "Sign & Close" to finalize your selections.

Need Help? Call 1-866-432-3280 Email support@studentlogbook.com or visit www.studentlogbook.com/support

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Appendix 5: Work related injury Process & Forms





WORKER'S REPORT OF INJURY OR OCCUPATIONAL DISEASE TO EMPLOYER

Section 53(3) of the *Workers Compensation Act* requires that, where a worker is fit, and on request of the employer, they must provide the employer with particulars of the injury or occupational disease on a report prescribed by WorkSafeBC and supplied to the worker by the employer. This is the report prescribed. If requested by employer, please complete this report as it appears. **Submit directly to employer.**

This report should be completed by the injured worker if fit to do so. It can be completed by another individual for signature by the injured worker.

Worker information		WorkSafeBC claim number	Customer care number
Worker last name		First name	Middle initial
Date of birth (yyyy-mm-dd)	Personal health number (from BC CareCard)	Social insurance number	
Address line 1		Address line 2	
City	Province/state	Country (if not Canada)	Postal code/zip
Home phone number (please include area code)		Business phone number (please include area code)	Business extension
Occupation			Gender M <input type="checkbox"/> F <input type="checkbox"/>

Employer information			
Employer organization name			
Type of business (if known)		Operating location (if known)	
Address line 1		Address line 2	
City	Province/state	Country (if not Canada)	Postal code/zip
Employer contact name		Employer phone number (please include area code)	Extension

Incident information			
1. Date and time of incident (yyyy-mm-dd)		2. Period of exposure resulting in occupational disease (yyyy-mm-dd)	
		From To	
3. My injury or disease was first reported to my employer on (yyyy-mm-dd) (please check one)			
at		TO: First aid <input type="checkbox"/> Supervisor <input type="checkbox"/> Office <input type="checkbox"/> Other <input type="checkbox"/> (please specify)	
4. Name of person reported to			
5. Did you receive first aid?		6. Date of first aid (yyyy-mm-dd)	
Yes <input type="checkbox"/> No <input type="checkbox"/>		7. Name of first aid attendant	
8. Did you go to the hospital, a medical clinic, or see a physician? Yes <input type="checkbox"/> No <input type="checkbox"/>		9. If yes, name of physician or provider (if known)	
10. Address of physician or provider (if known)			
11. Are you aware of any recent pain or disability in the area of your reported injury? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please explain			
12. Was protective equipment being used? Yes <input type="checkbox"/> No <input type="checkbox"/>		13. Were there any witnesses? Yes <input type="checkbox"/> No <input type="checkbox"/>	
14. The supervisor in charge at the time of my injury was			
15. Describe how the incident happened		16. Describe the injury in detail (what part of the body was injured)	
		17. Side of body injured Left <input type="checkbox"/> Right <input type="checkbox"/> Both <input type="checkbox"/> Not applicable <input type="checkbox"/>	



Worker's Report of Injury or Occupational Disease to Employer (continued)

Worker last name	First name	Middle Initial	WorkSafeBC claim number
Social insurance number		Personal health number from BC CareCard	

Incident information (continued)

18. Describe the work incident location (address, city, province) and where incident occurred (e.g. shop floor, lunchroom, parking lot)

19. Contributing factors—select AT LEAST ONE, and as many as applicable

Lifting <input type="checkbox"/>	lb <input type="checkbox"/> kg <input type="checkbox"/>	Animal bite <input type="checkbox"/>
Overexertion <input type="checkbox"/>	Struck <input type="checkbox"/>	Assault <input type="checkbox"/>
Repetitive (activity repeated over and over again) <input type="checkbox"/>	Crush <input type="checkbox"/>	Motor vehicle accident <input type="checkbox"/>
Slip or trip <input type="checkbox"/>	Sharp edge <input type="checkbox"/>	Unsure/other (please explain below) <input type="checkbox"/>
Twist <input type="checkbox"/>	Fire or explosion <input type="checkbox"/>	
Fall <input type="checkbox"/>	Harmful substance in the work environment <input type="checkbox"/>	

20. Did you or will you miss any time from work beyond the date of injury or exposure?
 Yes No

Signature and report date

21. Worker signature	22. Date of report (yyyy-mm-dd)
----------------------	---------------------------------

Additional information

The BC Legislature provides impartial advisers on all workers' compensation matters. The Workers' Advisers Office is independent and separate from WorkSafeBC and provides free advice and assistance to help injured workers with their claims. They have offices throughout the province and can be contacted at www.labour.gov.bc.ca/wab/ or by telephone: Richmond 604 713-0360, toll-free 1 800 663-4261; Victoria 250 952-4393, toll-free 1 800 661-4066; Kelowna 250 717-2096, toll-free 1 866 881-1188.

Personal information on this form is collected for the purposes of administering a worker's compensation claim by WorkSafeBC in accordance with the *Workers Compensation Act* and the *Freedom of Information and Protection of Privacy Act*. For further information about the collection of personal information, please contact WorkSafeBC's Freedom of Information Coordinator at PO Box 2310 Stn Terminal, Vancouver BC, V6B 3W6, or telephone 604 279-8171.



JIBC

School of
Health Sciences

Paramedic Academy

Appendix 6: Sample PCR and CWS

Ambulance Practicum - Patient Care Record

Patient Care Record

PCR #101

Student:	Date of Response:																																																		
Preceptor:	Station #:																																																		
Chief Complaint/Description of Incident:	Gender: M <input type="checkbox"/> F <input type="checkbox"/> Age:																																																		
History of Chief Complaint:	Vital Signs																																																		
	<table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <tr> <th style="width: 5%;">Time</th> <th style="width: 5%;">LOC</th> <th style="width: 5%;">Pulse</th> <th style="width: 5%;">Resp.</th> <th style="width: 5%;">B/P</th> <th style="width: 5%;">Skin</th> <th style="width: 5%;">Pupils</th> <th style="width: 5%;">SP02</th> <th style="width: 5%;">BG</th> <th style="width: 5%;">Other</th> </tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </table>	Time	LOC	Pulse	Resp.	B/P	Skin	Pupils	SP02	BG	Other																																								
	Time	LOC	Pulse	Resp.	B/P	Skin	Pupils	SP02	BG	Other																																									

Past Medical History:

Medications:

Allergies:

Focused Physical Exam/Functional Inquiry:

TIME	MEDICATIONS/PROCEDURES	RESULT



Ambulance Practicum - Patient Care Record

NOCP Reference Guide						
Area 1: Professional Responsibilities	Area 2: Communication	Area 3: Health & Safety				
P 1.1.a <input type="checkbox"/>	P 2.1.a <input type="checkbox"/>	P 3.1.e <input type="checkbox"/>	P 4.2.d <input type="checkbox"/>	P 4.4.d <input type="checkbox"/>	C 5.3.d <input type="checkbox"/>	P 6.1.c <input type="checkbox"/>
P 1.1.b <input type="checkbox"/>	P 2.1.b <input type="checkbox"/>	P 3.2.a <input type="checkbox"/>	P 4.2.e <input type="checkbox"/>	P 4.4.e <input type="checkbox"/>	C 5.4.a <input type="checkbox"/>	P 6.1.e <input type="checkbox"/>
P 1.1.c <input type="checkbox"/>	P 2.1.c <input type="checkbox"/>	P 3.2.b <input type="checkbox"/>	P 4.2.f <input type="checkbox"/>	C 4.4.f <input type="checkbox"/>	C 5.4.d <input type="checkbox"/>	P 6.1.f <input type="checkbox"/>
P 1.1.e <input type="checkbox"/>	P 2.1.d <input type="checkbox"/>	P 3.2.d <input type="checkbox"/>	P 4.3.a <input type="checkbox"/>	P 4.4.g <input type="checkbox"/>	P 5.5.c <input type="checkbox"/>	P 6.1.g <input type="checkbox"/>
P 1.1.h <input type="checkbox"/>	P 2.1.e <input type="checkbox"/>	P 3.2.e <input type="checkbox"/>	P 4.3.b <input type="checkbox"/>	P 4.4.h <input type="checkbox"/>	P 5.5.d <input type="checkbox"/>	P 6.1.k <input type="checkbox"/>
P 1.1.j <input type="checkbox"/>	P 2.1.f <input type="checkbox"/>	P 3.3.a <input type="checkbox"/>	P 4.3.c <input type="checkbox"/>	P 4.4.i <input type="checkbox"/>	C 5.5.o <input type="checkbox"/>	P 6.1.l <input type="checkbox"/>
P 1.1.k <input type="checkbox"/>	P 2.1.g <input type="checkbox"/>	P 3.3.b <input type="checkbox"/>	P 4.3.d <input type="checkbox"/>	C 4.5.a <input type="checkbox"/>	P 5.6.a <input type="checkbox"/>	P 6.1.o <input type="checkbox"/>
P 1.3.a <input type="checkbox"/>	P 2.2.a <input type="checkbox"/>	P 3.3.c <input type="checkbox"/>	P 4.3.e <input type="checkbox"/>	C 4.5.b <input type="checkbox"/>	P 5.7.b <input type="checkbox"/>	P 6.1.p <input type="checkbox"/>
P 1.3.c <input type="checkbox"/>	P 2.3.a <input type="checkbox"/>	P 3.3.f <input type="checkbox"/>	P 4.3.f <input type="checkbox"/>	P 4.5.c <input type="checkbox"/>	P 5.8.b <input type="checkbox"/>	C 6.1.q <input type="checkbox"/>
P 1.5.a <input type="checkbox"/>	P 2.3.b <input type="checkbox"/>	P 3.3.g <input type="checkbox"/>	C 4.3.g <input type="checkbox"/>	P 4.5.i <input type="checkbox"/>	C 5.8.c <input type="checkbox"/>	C 6.2.a <input type="checkbox"/>
P 1.5.b <input type="checkbox"/>	P 2.3.c <input type="checkbox"/>	P 3.3.h <input type="checkbox"/>	P 4.3.h <input type="checkbox"/>	Area 5: Therapeutics	C 5.8.d <input type="checkbox"/>	C 6.2.b <input type="checkbox"/>
P 1.5.c <input type="checkbox"/>	P 2.3.d <input type="checkbox"/>	Area 4: Assessment & Diagnostics	P 4.3.i <input type="checkbox"/>	C 5.1.a <input type="checkbox"/>	P 5.8.e <input type="checkbox"/>	C 6.2.c <input type="checkbox"/>
P 1.5.d <input type="checkbox"/>	P 2.4.a <input type="checkbox"/>	P 4.2.a <input type="checkbox"/>	P 4.3.j <input type="checkbox"/>	C 5.1.b <input type="checkbox"/>	C 5.8.h <input type="checkbox"/>	P 6.3.a <input type="checkbox"/>
P 1.6.a <input type="checkbox"/>	P 2.4.b <input type="checkbox"/>	P 4.2.b <input type="checkbox"/>	P 4.3.k <input type="checkbox"/>	C 5.1.c <input type="checkbox"/>	C 5.8.j <input type="checkbox"/>	P 6.3.b <input type="checkbox"/>
P 1.6.b <input type="checkbox"/>	P 2.4.c <input type="checkbox"/>	P 4.2.c <input type="checkbox"/>	P 4.3.l <input type="checkbox"/>	C 5.1.d <input type="checkbox"/>	Area 6: Integration	Area 7: Transportation
P 1.6.c <input type="checkbox"/>	P 2.4.d <input type="checkbox"/>		P 4.3.m <input type="checkbox"/>	C 5.1.h <input type="checkbox"/>	P 6.1.a <input type="checkbox"/>	P 7.1.a <input type="checkbox"/>
	P 2.4.e <input type="checkbox"/>		P 4.4.a <input type="checkbox"/>	P 5.2.e <input type="checkbox"/>	P 6.1.b <input type="checkbox"/>	
	P 2.4.f <input type="checkbox"/>		C 4.4.b <input type="checkbox"/>	C 5.3.a <input type="checkbox"/>		
			C 4.4.c <input type="checkbox"/>			

Airway Assessment:

Predictors of Diff A/W

- Poor mouth opening
- Receding jaw
- Short neck
- Poor atlanto-occipital ext.
- Facial maxillary trauma
- Inhalational burn
- Penetrating trauma to neck
- Mass (tumor, abscess, hematoma)

Predictors of Diff BVM

- Beard
- Obesity
- Old age
- Snores/stridor
- Toothless

3-3-1 Rule

- ___ Hyomental distance
- ___ Mouth opening
- ___ Ant. jaw protrusion

Mallampati Test

(1-4) ___

Laryngoscopy View

(I - IV) ___

Impression:

Preceptor Comments: (Strengths, weaknesses, recommendations)

Student Signature _____

Preceptor Signature _____



Clinical Worksheet

CWS #101

Student:	Date:
Clinician:	Hospital:
Chief Complaint/Description of Incident:	Gender: M <input type="checkbox"/> F <input type="checkbox"/> Age:

History of Chief Complaint:	Vital Signs									Other
	Time	LOC	Pulse	Resp.	B/P	Skin	Pupils	SP02	BG	

Past Medical History:

Medications:

Allergies:

Focused Physical Exam/Functional Inquiry:

TIME	MEDICATIONS/PROCEDURES	RESULT



Clinical Practicum - Clinical Worksheet

NOCP Reference Guide

Area 4 Assessment & Diagnostics	Area 5: Therapeutics	C 5.4.a <input type="checkbox"/> C 5.4.d <input type="checkbox"/> C 5.5.o <input type="checkbox"/> C 5.8.c <input type="checkbox"/> C 5.8.d <input type="checkbox"/> C 5.8.h <input type="checkbox"/> C 5.8.j <input type="checkbox"/> C 5.8.l <input type="checkbox"/>	Area 6: Integration
C 4.3.f <input type="checkbox"/> C 4.3.o <input type="checkbox"/> C 4.4.c <input type="checkbox"/> C 4.4.f <input type="checkbox"/> C 4.5.a <input type="checkbox"/> C 4.5.b <input type="checkbox"/>	C 5.1.a <input type="checkbox"/> C 5.1.b <input type="checkbox"/> C 5.1.c <input type="checkbox"/> C 5.1.d <input type="checkbox"/> C 5.1.h <input type="checkbox"/> C 5.3.a <input type="checkbox"/> C 5.3.d <input type="checkbox"/>		C 6.1.q <input type="checkbox"/> C 6.2.a <input type="checkbox"/> C 6.2.b <input type="checkbox"/> C 6.2.c <input type="checkbox"/>

Airway Assessment:		
Predictors of Diff A/W	Predictors of Diff BVM	Mallampati Test
<input type="checkbox"/> Poor mouth opening	<input type="checkbox"/> Beard	<input type="checkbox"/> Snores/stridor (1-4) ____
<input type="checkbox"/> Receding jaw	<input type="checkbox"/> Obesity	<input type="checkbox"/> Toothless
<input type="checkbox"/> Short neck	<input type="checkbox"/> Old age	
<input type="checkbox"/> Poor atlanto-occipital ext.		Laryngoscopy View
<input type="checkbox"/> Facial maxillary trauma		(I - IV) ____
<input type="checkbox"/> Inhalational burn	3-3-1 Rule	Impression:
<input type="checkbox"/> Penetrating trauma to neck	____ Hyomental distance	_____
<input type="checkbox"/> Mass (tumor, abscess, hematoma)	____ Mouth opening	
	____ Ant. jaw protrusion	

Clinician Comments: (Strengths, weaknesses, recommendations)

Student Signature

Clinician Signature


Appendix 7: NOCP Medication List by Term

<p>This list is marked with an “X” to indicate the groups of pharmacologic agents with which Advanced Care Paramedics should be familiar and which Term of the ACP Program they have been covered.</p> <p>The technical skill of medication administration is included in the profile as General Competency 5.8.</p> <p>The administration of any medication by a paramedic is at the sole discretion of the respective Medical Director.</p>			
		ACP	Covered in Term
A. Medications affecting the central nervous system.			
A.1	Opioid Antagonists	X	1
A.2	Anaesthetics		
A.3	Anticonvulsants	X	2
A.4	Antiparkinsonism Agents	X	3
A.5	Anxiolytics, Hypnotics and Antagonists	X	1
A.6	Neuroleptics	X	2
A.7	Non-narcotic analgesics	X	1
A.8	Opioid Analgesics	X	1
A.9	Paralytics		
B. Medications affecting the autonomic nervous system.			
B.1	Adrenergic Agonists	X	1
B.2	Adrenergic Antagonists	X	2
B.3	Cholinergic Agonists	X	2
B.4	Cholinergic Antagonists	X	1
B.5	Antihistamines	X	2
C. Medications affecting the respiratory system.			
C.1	Bronchodilators	X	2

		ACP	Covered in Term
D. Medications affecting the cardiovascular system.			
D.1	Antihypertensive Agents	X	2
D.2	Cardiac Glycosides	X	2
D.3	Diuretics	X	2
D.4	Class 1 Antidysrhythmics	X	1
D.5	Class 2 Antidysrhythmics	X	2
D.6	Class 3 Antidysrhythmics	X	1
D.7	Class 4 Antidysrhythmics	X	2
D.8	Antianginal Agents	X	1
E. Medications affecting blood clotting mechanisms.			
E.1	Anticoagulants	X	2
E.2	Thrombolytics	X	2
E.3	Platelet Inhibitors	X	2
F. Medications affecting the gastrointestinal system.			
F.1	Antiemetics	X	2
G. Medications affecting labour, delivery and postpartum hemorrhage.			
G.1	Uterotonics	X	3
G.2	Tocolytics	X	3
H. Medications used to treat electrolyte and substrate imbalances.			
H.1	Vitamin and Electrolyte Supplements	X	1
H.2	Antihypoglycemic Agents	X	1
H.3	Insulin	X	2
I. Medications used to treat / prevent inflammatory responses and infections.			
I.1	Corticosteroids	X	3
I.2	NSAID	X	3
I.3	Antibiotics	X	3
I.4	Immunizations	X	3
J. Medications used to treat poisoning and overdose.			
J.1	Antidotes or Neutralizing Agents	X	3



Appendix 8: BCAS Patient Privacy Policy

 BCAS POLICY	Policy:	
	PROTECTING PATIENT PRIVACY	
	Policy number: 5.1.1 Volume: 1	Approved by: Executive Officer
	Area: Access to Data and Information	Policy holder: Manager, Risk Management and Legal Support
Effective: 2011-01-26	Amended: New Policy	

Purpose

Privacy is integral to the paramedic-patient relationship. For effective emergency health services, patients must trust paramedics with their sensitive health information. Without trust, patients may not disclose critical information, may downplay their condition or may simply refuse treatment.

This policy ensures that dispatchers, dispatch superintendents, paramedics and unit chiefs perform their duties in a manner consistent with the paramedic's *Code of Ethics*, the *Freedom of Information and Protection of Privacy Act (FOIPPA)*, the *Privacy Act* and related policies.

Definitions

In this policy:

dispatch record	"Dispatch record" means an audio recording, a Dispatch Ticket, a CAD Event Record, an Event History Record or a Daily Log created by a Dispatch Operations Centre.
Patient Care Report	"Patient Care Report" means a <i>Patient Care Report</i> or a <i>Patient Care Specialty Report</i> .
patient information	"Patient information" means information, recorded or not, about a patient, a scene or a response time.
patient record	"Patient record" means a record related to a patient's health and includes a Patient Care Report, an ECG Rhythm Strip, an <i>Occurrence Report</i> and a dispatch record.



personal information	"Personal information" means information, recorded or not, about an individual whether alive or deceased.
regional legal coordinator	"Regional legal coordinator" means an employee appointed by a regional executive director to be responsible for administering legal and FOIPPA matters within a region.

Policy

Dispatchers and paramedics must only

- (1) collect patient information when necessary for providing emergency health services,
- (2) use patient information when necessary for providing emergency health services, or
- (3) disclose patient information if authorized by policy.

The duty of confidentiality exists at all times, regardless of whether

- (1) the employee is on- or off-duty,
- (2) the employee ceases to be an employee, and
- (3) a patient or a former patient is alive or deceased.

Paramedics and dispatchers must not deny service to a person refusing to provide personal information if service can be safely and effectively provided without the personal information.

For the purposes of this policy, a "paramedic" includes a student enrolled in the Practicum Education and Practicum Program.

A. DISPATCH RESPONSIBILITIES FOR PROTECTING PATIENT PRIVACY

- (1) Dispatchers must ensure that they record all personal information as accurately and completely as possible.
- (2) Dispatchers and dispatch superintendents may disclose patient information to
 - (a) paramedics when necessary for providing emergency health services,
 - (b) police, a coroner or other statutory authority conducting an investigation
 - (i) at the scene of a call or event, or
 - (ii) if approved by a regional legal coordinator,



- (c) regional legal coordinators or managers responding to *FOIPPA* requests, court orders, or search warrants,
 - (d) an executive director or an employee authorized by an executive director who requires patient information in order to fulfill his or her employment duties, or
 - (e) a patient's next of kin or a friend identified by the patient.
- (3) Dispatch superintendents must ensure that dispatch records are secure from unauthorized use, disclosure, destruction or loss.

B. PARAMEDIC RESPONSIBILITIES FOR PROTECTING PATIENT PRIVACY

- (1) Paramedics providing services to patients unable to consent to the collection of their information may, if necessary to provide services, collect that patient's personal information from any person able to provide reliable information.
- (2) Paramedics must only record patient information on one or more of the following:
 - (a) a *Patient Care Report*;
 - (b) an *Occurrence Report*; or
 - (c) any document required by the Emergency Medical Assistants Licensing Board.
- (3) Paramedics must ensure that they record all patient information as accurately and completely as possible.
- (4) Paramedics are prohibited from recording any patient information in a "black book" or in any other personal notebook.
- (5) Paramedics may only disclose patient information to
 - (a) hospital staff or medical professionals presently involved in that patient's continuum of care and at the time the patient is admitted,
 - (b) police, a coroner or other statutory authority conducting an investigation
 - (i) at the scene of a call or event, or
 - (ii) if approved by a regional legal coordinator,
 - (c) a regional legal coordinator or a manager responding to a *FOIPPA* request, a court order or a search warrant,
 - (d) a patient's next of kin or a friend identified by the patient,



- (e) an executive director or an employee authorized by an executive director who requires patient information in order to fulfill his or her employment duties, or
 - (f) a lawyer working for the Ministry of Attorney General, or, in a court if under subpoena and if arranged through a regional legal coordinator.
- (6) Paramedics must not discuss patient information where third parties not involved in a patient's care may overhear.
 - (7) Paramedics must ensure that patient records are secure from unauthorized use, disclosure, destruction or loss.
 - (8) Paramedics are responsible for accurately, and completely, scanning patient records into PCIS.
 - (9) A paramedic must not use a camera or any other electronic device to record patient information. Despite this restriction, management may authorize photography when necessary for
 - (a) accident investigations involving BCAS or government vehicles,
 - (b) training,
 - (c) medical purposes, or
 - (d) any other purpose approved by the Commission.

C. RESPONSIBILITIES OF UNIT CHIEFS

- (1) Unit chiefs are responsible for conducting periodic reviews of Patient Care Reports to ensure that each report
 - (a) contains the minimum information as required by *PCIS Minimum Information*,
 - (b) has been scanned and verified,
 - (c) is undamaged, and
 - (d) includes all supporting records.
- (2) Unit chiefs must also ensure that patient records stored in a station are secure from unauthorized use, disclosure, destruction or loss.

D. DISCLOSING PATIENT RECORDS

- (1) Unless a requester is a person listed in A(2) or B(5), paramedics must neither confirm nor deny providing service to anyone, and must refer the requester to the "Patient Care Records" page on the BCAS public website at www.bcas.ca.



- (2) A dispatcher or a paramedic may release patient information or personal information to police for a *Criminal Code* or a *Motor Vehicle Act* investigation or to a coroner for a *Coroners Act* investigation.
- (3) Dispatchers and paramedics must report to a regional legal coordinator all police or coroner requests for personal information. The regional legal coordinator must then require the police or coroner to document their request in compliance with the *BCAS Legal Coordinator Release of Patient Records and Legal Process Manual*.
- (4) Paramedics, unit chiefs, dispatchers and dispatch superintendents must refer all other requests for information, records or interviews from statutory authorities to the regional legal coordinator within their region.
- (5) Dispatchers and paramedics must not provide personal information to any police officer claiming to be conducting an investigation on behalf of a coroner. Dispatchers and paramedics must immediately report all such requests to the regional legal coordinator.